ARTS
Addiction and Recovery Treatment Services

The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant

**SUD Technical Assistance Webinar Series**

# VIRGINIA MEDICAID: 22—

## OPIOID USE DISORDER & CLIENTS IN NEED OF STABLE HOUSING

MARCH 22 & 23, 2021

*Department of Medical Assistance Services*

# Welcome and Meeting Information

- WebEx participants are muted
  - Please use Q&A feature for questions
  - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmas.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series

# COPYRIGHT

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- **Last revision: March 18, 2021**

# DISCLAIMER

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

# Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

**If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.**

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

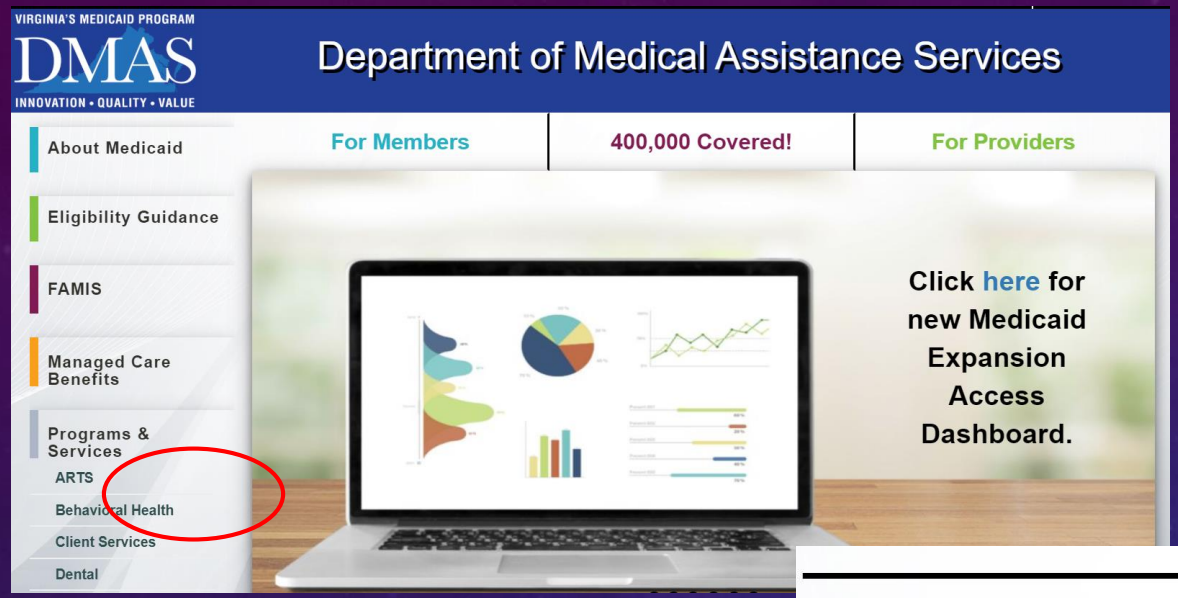
# Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training
  - https://getnaloxonenow.org/
    - Register and enter your zip code to access free online training

- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!

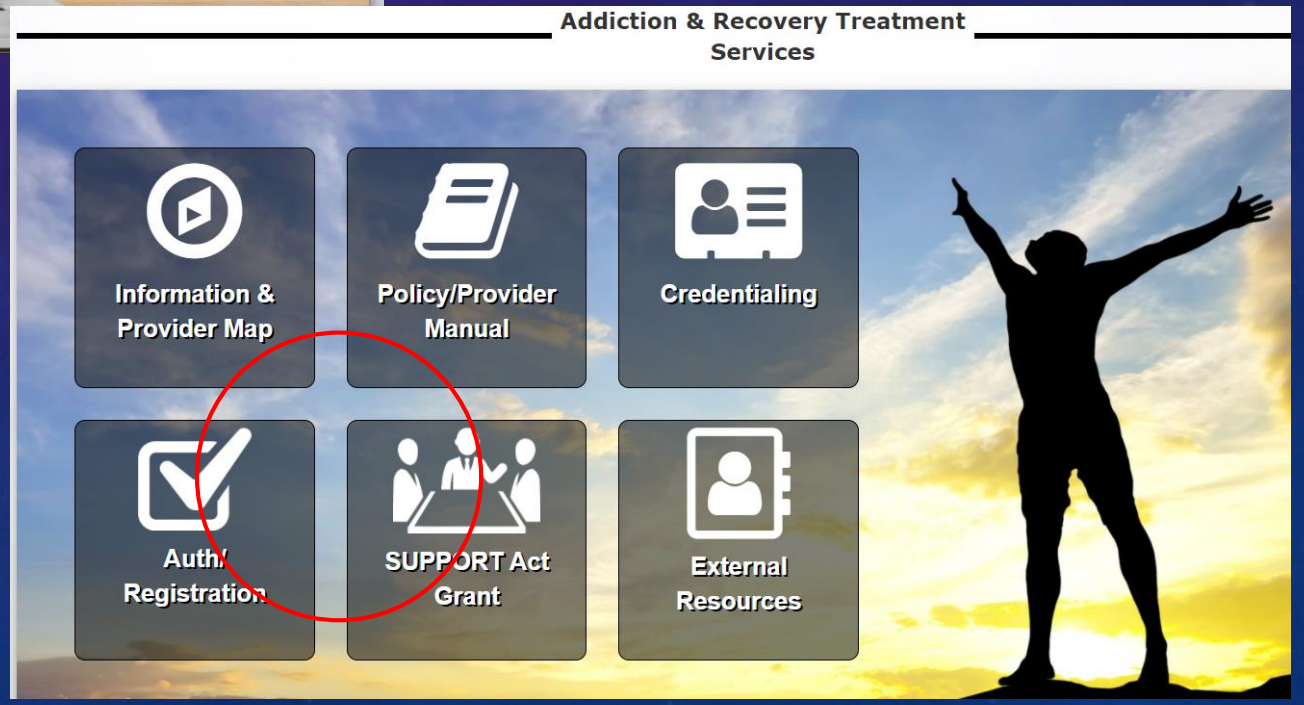
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422
  - Available only to Virginia residents, intramuscular administration

# Website Update




DMAS Home Page: https://www.dmas.virginia.gov/#/index

ARTS Home Page: https://www.dmas.virginia.gov/#/arts



# SUPPORT Act Grant Website - https://www.dmas.virginia.gov/#/artssupport

## SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

### Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

### Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

### Period of Performance

September 2019 - September 2021

### Grant Email

SUPPORTgrant@dmas.virginia.gov

### Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

### Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

### Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

### Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

### SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

# HAMILTON RELAY TRANSCRIBER (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

# TODAY'S PRESENTERS

**Paul Brasler**, M.A., M.S.W.

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SUPPORT Grant Behavioral Health Addiction Specialist

Department of Medical Assistance Services

**Ara Krisela Mendoza**

Balance of State CoC Program Coordinator, Homeless and Special Needs Housing

Virginia Department of Housing and Community Development (DHCD)

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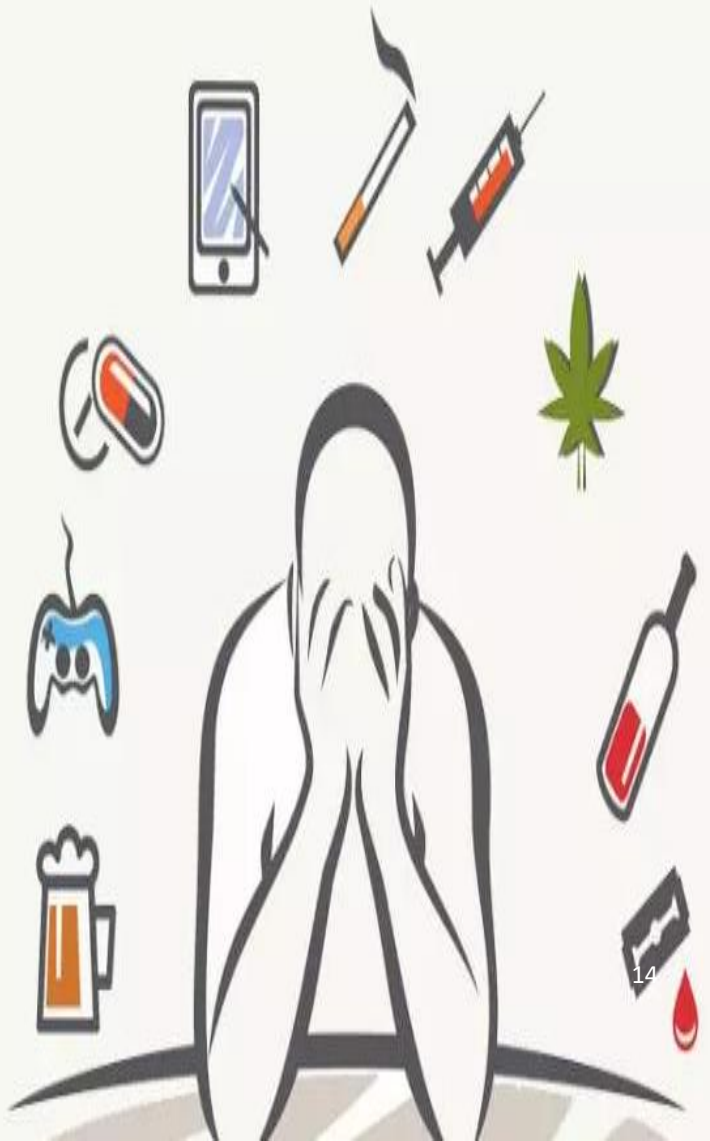
# LANGUAGE

- We want to use “Person-Centered language”
  - Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
  - Not “Addiction,” but **Substance Use Disorder (SUD)**
  - Not “Abuse,” but **Use**
  - Not “Clean,” but **In Recovery** or **Testing Negative**
  - Not “Dirty,” but **Testing Positive**
  - Not “Relapse,” but **Return to Use**
- At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms
- Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)

# TWO IMPORTANT THINGS YOU MUST DO BEFORE WORKING WITH ANY CLIENT

I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you
II. **Find something to like** in the person you are working with—connect with them on a human level

**NO ONE** *sets out to become addicted to chemicals or behaviors*



# MYTHS & STEREOTYPES

- Drug exposure alone causes SUD
- Drug treatment does not work
- We are winning the “War on drugs”
- Addiction is completely a choice
- Addiction is totally due to genes
- A person can love someone enough to change them
- Most people with SUD are homeless and/or unemployed
- A person will only stop using drugs when they “hit bottom”

# ADDICTION DEFINED: ASAM

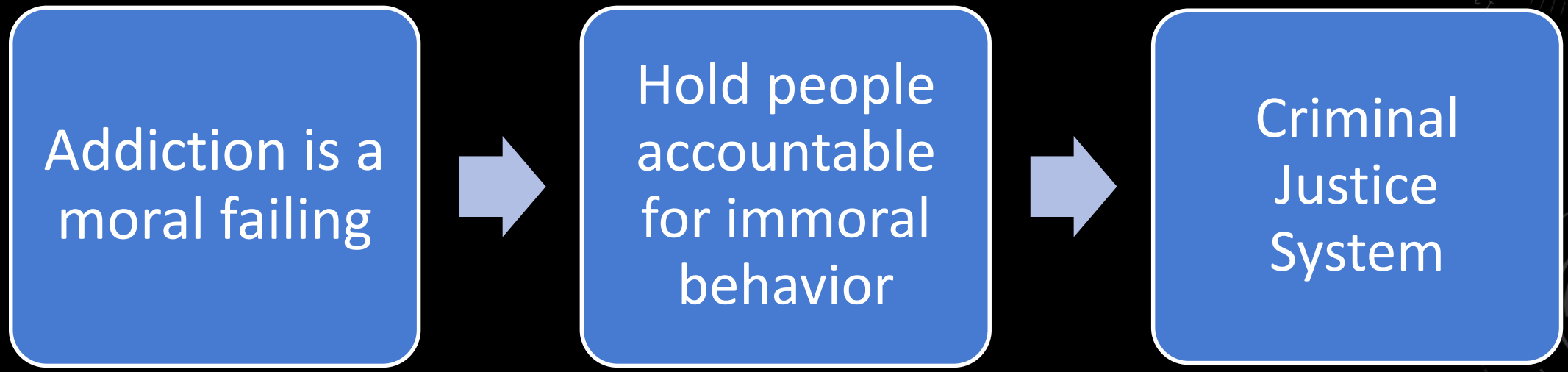
*Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.*

*Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.*

Adopted by the ASAM Board of Directors September 15, 2019

# MODEL OF SUD DICTATES THE APPROACH TO TREATMENT/INTERVENTION

**Moral Model** (Avery & Avery, 2019, p. 96)



# MODEL OF SUD DICTATES THE APPROACH TO TREATMENT/INTERVENTION

**Biopsychosocial Model** (Avery & Avery, 2019, p. 96)

# RECOVERY DEFINED

"…A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life."

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)

# OPIOIDS: MORTALITY & MORBIDITY

- In 2018, an estimated 10.3 million people in the U.S. misused opioids, with 2 million meeting criteria for Opioid Use Disorder (ASAM, 2020)
- In 2018, more than 115 people in the U.S. died each day from an opioid overdose (Andraka-Christou, 2020)
- In 2019, 70,980 people died of drug overdoses, with 50,042 involving opioids (CDC, 2020)
- "81,230 overdose deaths occurred in the U.S. in the 12 months ending in May 2020" (CDC, 2020)
  - This increase is being driven by a proliferation of synthetic opioids, notable fentanyl and fentanyl-analogues

# HEROIN

- “Dope,” “junk,” “smack,” “horse,” “shit,” “cheese…”
- One to four times the strength of morphine (metabolized into morphine in the body)
- First synthesized in 1874; marketed in 1898 by Bayer
- Crosses the blood-brain barrier quicker than morphine: Euphoria occurs 10 - 15 seconds after insufflation or smoking, 5 - 8 mins. after muscular injection and less than 20 seconds after intravenous injection
- Sold in **two** grades:
  - Lower grade (#3), “brown sugar;” “black tar” – usually injected (intravenous, intramuscular, or skin-popped)
  - Higher grade (#4 = up to 90% pure), “China White” – can be insufflated (snorted), smoked or injected

# HEROIN

- Shooting heroin (or any other injectable drug), increases the user's potential of contracting HIV, Hepatitis B or C, and developing **abscesses**
  - Regular use causes the veins to narrow and harden
- **Heroin**, like all opioids, **decreases respiration**, which is the leading cause of overdose deaths
- Most heroin users consume other drugs, particularly alcohol, nicotine, benzodiazepines and stimulants
  - Most fatal heroin overdoses are not the result of heroin alone, but heroin and another drug in combination, usually a depressant

# SELECTED PRESCRIPTION OPIOIDS

- **Oxycodone:** One-and-a-half to two times the strength of morphine
  - OxyContin®, Percocet®, Percodan®, and Tylox® are all trade names and may include another analgesic like acetaminophen or aspirin
- **Hydromorphone:** 5 – 8 times stronger than morphine
  - Dilaudid®
- **Oxymorphone:** 10 times stronger than morphine
  - Opana®, Numorphan®, and Numorphone®

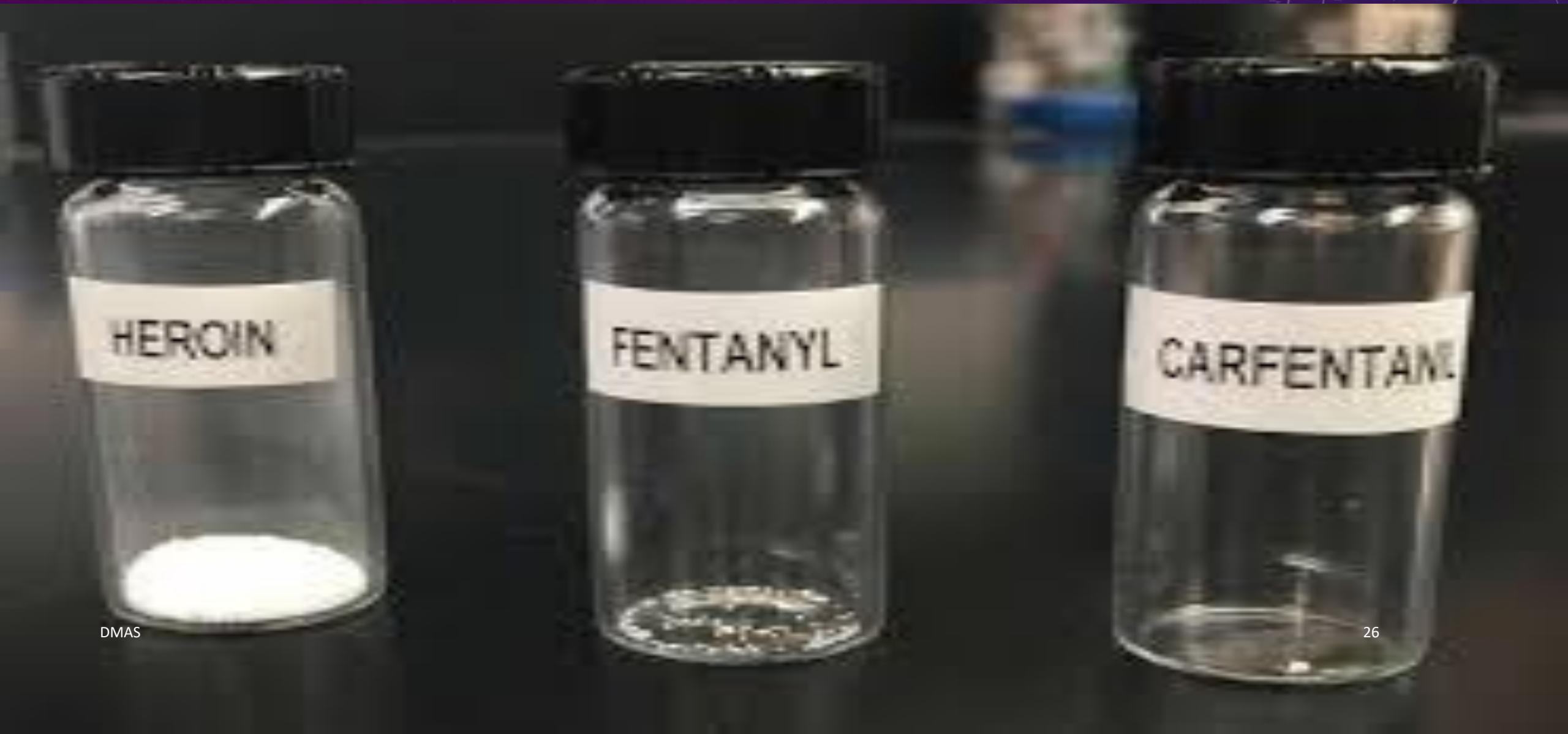
# FENTANYL

- The most powerful of all opioids, about **80** times more potent than morphine
- Used to treat chronic pain, acute pain, and in surgical procedures
- Nearly half of opioid-related deaths in 2016 - 2019 involved fentanyl—most of it illicitly produced
  - Transdermal patches can be chewed by users or the drug is extracted physically and/or chemically
- Street versions are also available ("China White"), and this is sometimes confused with heroin, resulting in overdose deaths—much of this fentanyl is illicitly manufactured in China; India is also emerging as a source (DEA, 2020)

# FENTANYL

- Fentanyl is being found in other drugs: Cocaine, methamphetamine, and illicitly-manufactured Alprazolam
  - This is likely due to cross-contamination as drugs are diluted and repackaged as they move down the supply chain
  - Fentanyl was involved in 40% of cocaine overdose deaths in 2016
- Sometimes sold in gelatin capsules (“Beans”) to users who prefer fentanyl to heroin
- Most illicit fentanyl comes into the U.S. through border crossings and the mail system
- There are thousands of Fentanyl analogues, including: **Acetyl Fentanyl, Sufentanil** and **Carfentanil** (100 times more potent than regular Fentanyl)

# PERSPECTIVE…



# PHARMACOTHERAPY
## (MEDICATION-ASSISTED THERAPY)

# PHARMACOTHERAPY FOR OPIOID USE DISORDER

- Methadone and Buprenorphine (the active ingredient in Suboxone) are both opioids—human-made chemicals that are like opiates (medicines made from opium)
- Methadone was approved for opioid use disorder treatment in 1947 and Buprenorphine in 2002
  - Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
  - Given by a licensed provider and administered in oral form (an injectable form of buprenorphine is available)
- Behavioral health treatment is an important part of MAT, but clients should **not** be forced to receive counseling to be able to receive pharmacotherapy

# METHADONE & BUPRENORPHINE THERAPIES

- The use of either chemical as part of opioid treatment is called Medication-Assisted Treatment (MAT) and has been recognized and accepted by the medical community for decades
- Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called “dope sickness”) and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use
  - **Neither of these chemicals, when used as prescribed, will get the client high**
- Both chemicals allow the brain to heal from opioid misuse and provide opportunities for the client to address the underlying causes of their SUD

# BUPRENORPHINE

- An **opioid agonist** in low doses and an **antagonist** in high doses, often combined with Naloxone: Suboxone®
  - In this formulation, should the patient try to inject the drug (instead of taking it orally), they will theoretically go into withdrawal symptoms (but people have found ways around this)
  - Suboxone is delivered in a buccal film or pill
  - Less respiratory depression than Methadone
- Has a “ceiling effect” (at 32 mg) which makes overdose less likely—except when mixed with alcohol
- In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine

# BUPRENORPHINE
## (ANDRAKA-CHRISTOU, 2020, P. 44)

- "Buprenorphine has greater affinity for the brain's opioid receptors than other opioids, meaning it binds more tightly to the receptors, so it displaces other opioids already on the brain's receptors, after which it blocks the effects of subsequent opioids"
- "Even though buprenorphine has greater *affinity* for the opioid receptor, it actually has weaker intrinsic *activity* [italics in original] at the opioid receptors relative to methadone, meaning it creates less cellular activity, so people with OUD taking buprenorphine as prescribed are less likely to feel euphoria than people taking methadone as prescribed"

# NALTREXONE & NALOXONE

- These opioids only have antagonistic properties; they will cause an opiate user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)
- **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
  - Also blocks the euphoric effects of opioids, cocaine, and alcohol
  - Time-release injectable versions and implant versions are available
- **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose

# CARE COORDINATION DEFINED

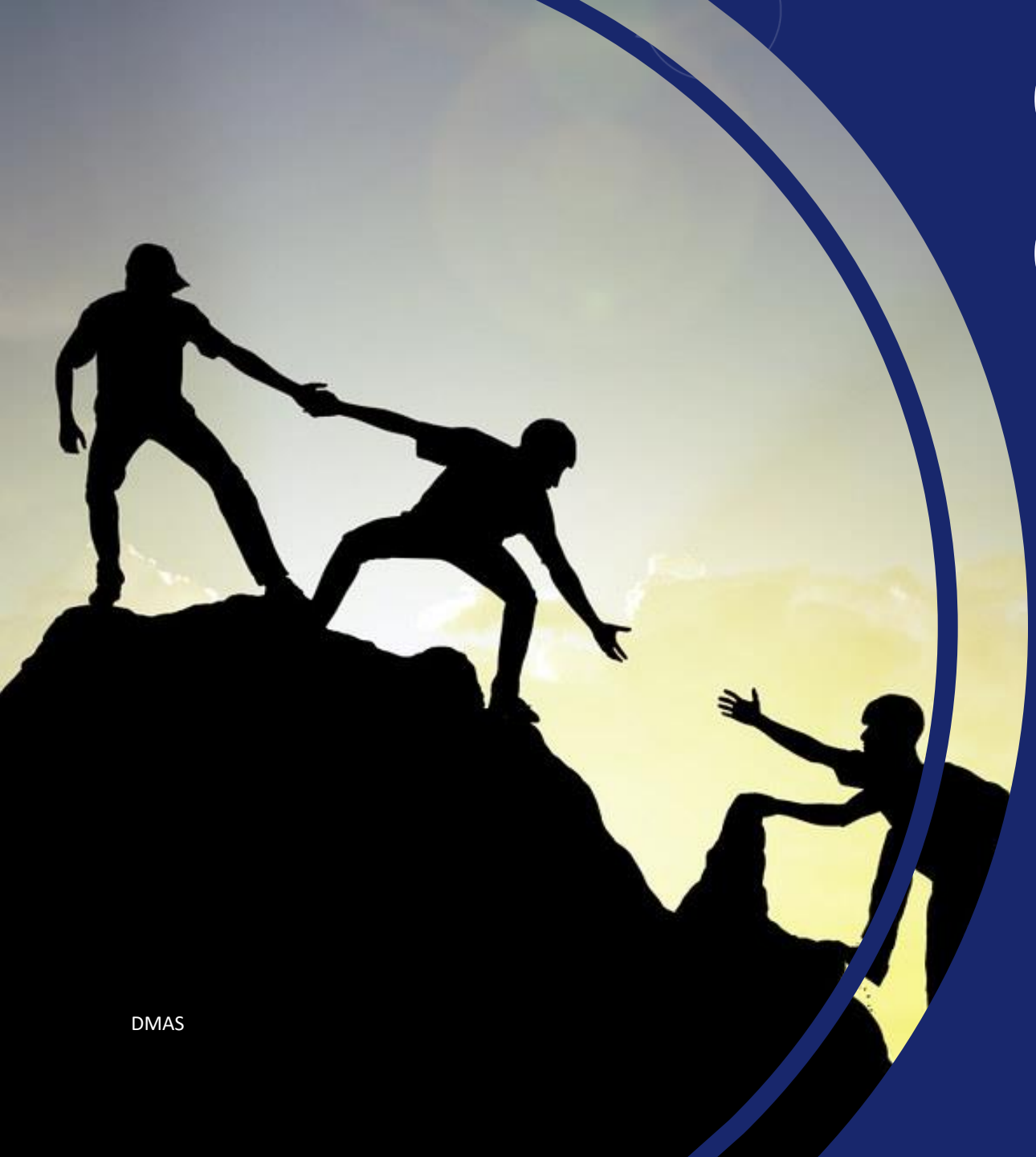
A coordinated approach to the delivery of health, substance use disorder, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals.

(CSAT, 2000, p. xiii)

# WHY IS CARE COORDINATION SO IMPORTANT IN SUD TREATMENT

(CSAT, 2000, P. XIII)

1. Retention in treatment is associated with better outcomes, and a principal goal of care coordination is to keep clients engaged in treatment and moving toward recovery
2. Treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance use
3. Comprehensive SUD treatment often requires that clients move to different levels of care or systems; case coordination facilitates such movement



# CARE COORDINATION

- The primary goal of care coordination is to help clients connect with services and resources that enhance their recovery
- CC starts by understanding the client's Recovery Capital

# CARE COORDINATION: BUILDING ON RECOVERY CAPITAL

**Personal Recovery Capital:** The client's physical health, emotional supports and things that support recovery (housing, income, insurance, food, safety)

**Family/Social Recovery Capital:** The resources and support available to the client from their family and friends (emotional, financial, help with childcare, transportation)

**Community Recovery Capital:** Resources available in the client's community (healthcare, childcare, transportation, housing, etc.)

# SOME CARE COORDINATION NEEDS

- Medical appointments
- Medical treatment
- Obtaining health insurance
- Dental care
- Transportation
- Childcare
- Job search
- Housing
- Enrolling in job training
- Legal aid
- Meeting legal system obligations (coordinate with probation/parole)
- Financial assistance
- Obtaining food vouchers
- Access food pantries
- Clothing
- Enrolling children in school
- Immigration needs
- Additional mental health needs

# HOMELESSNESS

- “The Department of Housing and Urban Development reported that approximately 553,000 people experienced homelessness in the United States on any given night in 2018” (SAMHSA, 2020, p. 167)
- **“Housing is more than just physical shelter. It is a social determinant of health and is essential for individual physical, emotional, and socioeconomic wellbeing.** Housing affects communities, governments, and nations through its impact on the economy, healthcare system, workforce, and more [**Bold** in original]” (SAMHSA, 2020, p. 168)

# PEOPLE EXPERIENCING HOMELESSNESS & SUD (SAMHSA, 2020, P. 167 – 168)

- Spinelli et al. (2017) found that among a group of people ages 50 and older who were experiencing homelessness:
  - 63 percent had used an illicit substance in the previous 6 months
  - 49 percent drank alcohol in the past 6 months, including 26 percent whose alcohol use was of moderate or greater severity and 15 percent whose use was of high severity
  - 10 percent reported binge drinking
  - 33 percent had current symptoms of PTSD
  - 38 percent had current symptoms of Major Depressive Disorder
  - 33 percent reported experiencing childhood physical abuse, and 13 percent experienced childhood sexual abuse

# Housing First Principles

- Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements.

- Central tenant of housing first is that everyone is houseable but some households do need additional supports to maintain their housing stability.

- Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to exit to permanent housing.

# Core Components

- No programmatic prerequisites to permanent housing entry
- Low barrier admission policies
- Rapid and streamlined entry into housing
- All supportive services are voluntary
- All services are client driven
- Tenants have full rights, responsibilities, and legal protections

HOUSING FIRST PHILOSOPHY

## THEN

- People needed to be “housing ready”
- “Earn” housing by completing a program, saving money, etc.

## NOW

- Everyone is “housing ready”
- Services informed by harm reduction and motivational interviewing

# WHAT IS AN EMERGENCY CRISIS RESPONSE SYSTEM?

- An effective crisis response system accomplishes the following goals
  - Identifies those experiencing homelessness
  - Prevent homelessness when possible
  - Connect people with housing quickly
  - Provide services when needed.

# HOMELESSNESS AND HOUSING FIRST

- Housing First operates as a holistic approach to addressing homelessness
- Homelessness is first and foremost a housing problem and should be treated as such
- Housing is a right to which all are entitled
- Issues that may have contributed to a household's homelessness are best addressed once they are housed

# CLIENTS EXPERIENCING HOMELESSNESS & SUD TREATMENT

- “Sober living” houses can be helpful for people who are highly motivated, but their tendency to kick out people if they use substances can be problematic
- Ideally, a **Housing First** model should be attached/integrated with a program(s) that addresses medical, mental health, SUD treatment, dental services, vocational/training services and other coordinated services that are client-centered and can help clients maintain housing

# CASE EXAMPLE: “SHARED MEDICAL APPOINTMENTS” – ONE AGENCY’S EFFORT TO HELP PEOPLE WITH OUD WHO WERE UNHOUSED

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